Final draft.

In: Atkinson, S., Hunt, R. (Eds.) (2019) *GeoHumanities and Health*. Springer, New York.

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Multiplicity and Encounters of Cultures of Care in Advanced Ageing

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> I have never created work of such quality. I am amazed how I managed to produce this…. Yes, I think I am quite capable.
>
> [Alice, nursing home resident]

Introduction

The contemporary and future trends of ageing populations include the growing numbers of those with advanced ageing who require institutionalised support. Caring for those with advanced ageing confronts debates around the meanings of care, from the concerns of medicine and social welfare with issues of quality and human rights through feminist engagements with labour and practice, value and ethics. Guidance for the provision of elder care has largely emerged from the medical and social sector in which care is framed as a potentially universal practice that enables compliance with a universal ethic of how the elderly are to be treated. This is evident, for example, within the WHO's Healthy Ageing Agenda in which long-term care is enshrined within a framework of universal rights, freedoms and dignity (WHO 2016). This universalising approach to care is, however, predominantly based on discussions of how an ethic of care is understood and practiced in the global north and feminist scholars have called for greater attention within care-focussed research to the diversity, dynamism and setting of the practice and ethics of care (Raghuram, 2016). This critique is complemented by more practical efforts undertaken to recover some of the identities, memories, and places that often become reduced through physical and mental constraints associated with advanced ageing. Such efforts aim to challenge and expand dominant perceptions of what ageing bodies can, and should, do and feel (Milligan et al.,

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2005), by drawing on the creative arts within explicitly inter-disciplinary projects. Those exploring the benefits for seniors from participation in the creative arts with the spatiality of an interdisciplinary geohumanities approach include Rose and Lonsdale (2016) who seek to recover and reimagine those landscapes of particular emotional significance and security through painting, Luján Escalante et al., (2017) who demonstrate the potential of creative practices to facilitate the inclusion of people with dementia as co-designers in digital innovations for their support and Herron et al. in this volume who engage a wider set of benefits from dance than are often considered. These explorations all involve collaborations across not only different academic disciplines but also with arts practitioners and providers of care. Here, we continue in this approach of a transdisciplinary geohumanities (Dear et al., 2015) through a collaboration between an artist working as both an arts-and-health practitioner and an academic, a social scientist working in both geography and the medical humanities, and the managers, carers and residents of a nursing home in Singapore. Despite this attention to practice, however, there has been, to date, relatively limited development of how a creative arts-based practice may relate to care and to the dominant universalising practice of care. The chapter, therefore, seeks to explore and conceptualise what we understand to be different cultures of care evident in the practices of the nursing home team and of the arts-practitioner.

Culture is a definitionally complex term with myriad of definitions to be found across the spectrum of academic research. We favour the brief elegance of Redfield, following the Lancet Commission on Culture and Health who defines culture as, 'conventional understandings manifest as art and artefact' (cited in Napier et al., 2014: 1608). This definition captures not only the 'the various complex systems of meaning that constitute everyday life' (Gilleard and Higgs, 2014: 2) and the shared and taken-for-grantedness of those meanings, but also stresses their inseparability from practice and materiality. Engaging care through a concept of culture then demands 'digging deep' (Killett et al., 2016) to reveal those taken-for-granted assumptions, which comprise ethos and underpin practice and which, by definition, are rarely explicitly articulated. We combine two rather different entry-points for 'digging deep' in order to respond to Raghuram's call for attention to diversity, dynamism and setting. While Raghuram (2016) proposed encounters between geographically differentiated cultures, we seek to reveal co-existing orientations to the practice and ethic of care within

the same shared historical and geographical setting. In this we favour the approach of Mol (2010) who focuses on the mixing of values and practices, and how they interact and shape one another, within the specificities of time and place. In particular, Mol teases out the diverse logics (Mol, 2008) and processes of 'valuing' (Mol, 2010; Heuts and Mol, 2013) that adhere to different understandings of notions such as care. By ethnographically documenting the various meanings given to what makes something good or bad, and the practices undertaken to make it so, for example, in relation to the terms independence and dependence (Struhkamp et al., 2009), she and her colleagues reveal a multiplicity of values and logics to care being expressed and entangled within a single setting.

Our study builds on elements of both Raghuram's differentiated cultures of care and Mol's co-existing values of care to better comprehend multiplicity and encounter in cultures of care in advanced ageing. We draw on a single case study of a long-term care home for the advanced elderly in Singapore. The practices of care in institutionalised homes for those who are particularly vulnerable, sometimes physically, sometimes mentally and often both, affords a space in which we encounter several constituencies with different sets of priorities, desires and experiences of the home. We therefore engaged these constituencies in discussions of expectation, intentions and experiences of working and living in the home. Alongside this exploration of the everyday variations in the cultures of care across different constituencies within the home, we also intentionally staged an exceptional encounter between cultures of care associated with explicitly differentiated traditions of practice. The project introduced into the largely medicalised ethos and practice, a programme of creative arts participation predicated on rather different practices and assumptions. The chapter, thus, describes multiple values and practices of care, sometimes contrasting, sometimes complementary, in a residential home for advanced ageing that emerge through both everyday and exceptional spaces of care and from differently positioned constituencies involved in the home. We conclude by exploring the relationships between these, their groundings in different logics and the implications of differentiated normative schema for variously 'tinkering with' or 'reforming' care provision.

Advanced Ageing and Residential Care

Residential care homes have become well-established in Europe, but countries that traditionally emphasised caring for the elderly in the family setting, including Singapore, are now also witnessing a rapid growth of institutionalised elder care. Singapore has one of the world's highest rates of ageing, along with several other countries in South-East Asia, for example, Japan, and while the numbers of residents in institutionalised facilities are still relatively low, these are increasing rapidly with the expectation of continued growth of the care home sector (Wong et al., 2014). Nursing homes in Singapore reflect trends in the global labour market, with the hands-on care labour undertaken largely by foreign migrant workers, particularly from the Philippines or Myanmar, while Singaporeans occupy the higher level management roles (Huang et al., 2012; Wong et al., 2014). In this, Singapore mirrors other countries in which caring for the elderly is devalued, usually feminised, often coloured, 'because the elderly are regarded as a marginal group whose bodies are associated with images of decay, disease and disgust (deriving from the loss of control over basic functions)' (Huang et al., 2012: 198; Twigg, 2006). Associated, at least in part, with this view of elder care as low grade or dirty work and with the rapid growth in the market for elder care provision, a large percentage of countries have developed regulatory frameworks to mitigate the risk of poor standards of care (Wong et al., 2014).

The importance of providing a good standard of care in relation to bodily hygiene for those no longer able to do this themselves privileges the body and the bodily deterioration with age. Other care-related activities in residential homes for the elderly likewise largely reflect a medical approach in which priority is given to physical care through bodily maintenance and limited physical exercise. The disadvantage of viewing the elderly in residential care as primarily in need of care for physical maintenance is that this becomes blurred with viewing the elderly as largely passive recipients of the care provided. As a result, the provision of activities to engage or entertain often have an instrumental purpose in promoting movement or in occupying the residents' time rather than promoting leisure, enrichment or quality of life (Theurer et al., 2015). While physical activity benefits the health and wellbeing of people in later life, an exclusive attention to this overlooks the concomitant benefits that derive from an engaged lifestyle (Lennartsson and Silverstein, 2001; Son et al., 2007; Wang et al., 2002). Medicalised care that attends only to the bodily needs of a 'condition', in this case ageing, implicitly limits the identity of the person to that condition (Mclaughlin, 2006). Typically,

residential homes tend to be associated with top-down governance and with little opportunity given for input from the residents about how things are organised, what activities they might prefer or how they themselves might be active participants in what has become their home. In effectively limiting the opportunities and access to the resources and technologies for an engaged lifestyle, the care for the residents in the nursing home produces a leisure-scarce space with implications for health and wellbeing outcomes (Hutchison and Nimrod, 2012; Iwasaki, 2007). There has been critique and calls for new approaches to providing residential care, particularly in terms of the inclusion of the resident voice and building connections between the residential home and other organisations in the neighbourhood. The culture-change movement in the US, for example, has campaigned since at least the nineteen-nineties for resident-centred care that promotes a more home-like environment through smaller residential sub-units, continuity in the care teams and greater involvement in decision-making for both residents and the care workers (Koren, 2010; Rahman and Schelle, 2008). In particular, the culture-change movement responded to the three 'plagues' of nursing home life: boredom, loneliness, and helplessness (Thomas, 1996), and these resonate with three of the basic needs articulated by self-determination theory: autonomy, relatedness and competence (Deci and Ryan, 2008; Shura et al., 2010). While calls to reform care provision in residential homes have repeatedly emphasised the need to improve autonomy and social interaction, unfortunately, boredom, helplessness and competence have received relatively little attention (Shura et al., 2010). The provision of activities in residential care homes are frequently identified and programmed with very little input, if any, from residents. Moreover, the activities are often little more than passive forms of entertainment that demand nothing from the residents and are subsequently rather childlike or patronising in their simplicity. Rather than offer depth of experience, these forms of leisure appear designed primarily to keep the residents occupied, to pass the time and mask the lack of purpose or meaning in residential home life (Theurer et al., 2015). Certainly, there appears to be little attention to occupational activities which are explicitly designed to care for the residents' continued feelings of competency.

This brief and partial review of the literature related to care provision in residential homes supports the claims made by Raghuram (2016) that understandings of care are dominated by those of the global north and that we need for a more geographically differentiated accounts.

The approach in much of the literature on care homes aims and claims to offer generalizable, perhaps universally so, observations and insights. The offerings are premised on an, often implicit, normative framework of what residential care provision needs to entail. Those arguing for various forms of cultural change explicitly position themselves as promoting justice for those least powerful within the homes and as seeking universal principles for how care should be provided. The ethic of care espoused within feminist social theory does something rather different to this; rather than seek universal principles grounded in an ethics of justice, it argues for awareness of the multiplicity of norms or goods on which care may be and could be defined and argues, '[i]nstead, care implies a negotiation about how different goods may co-exist in a given, specific, local practice' (Mol et al., 2010: 13). As such, cultures of care are to be comprehended not as distinct entities, but as multiple, relational and dynamic, as both mutually complementary and conflicting, and as situated entanglements of the material, affective, normative labour and practices of doing care, as Puig de la Bellacasa states in relation to thinking with care: '…it is important to insist that knowledge-making based on care, love and attachment is not incompatible with conflict; that care should not be reduced to smoothing out of differences' (Puig de la Bellacasa, 2012: 204).

Living at Evercare

Everyday living in our case study residential home, which we are calling Evercare, showed many of the features typically criticised within the reform movements. At present, the public image of nursing homes in Singapore is both highly negative and stigmatised with new developments having been met with public protest (AsiaOne, 2012). These are pervasive and residents of Evercare admitted that they too had similarly cynical impressions of residential living, prior to admission.

In part, these attitudes both reflect and inform the ways in which elder care is conceived and practiced. Our case study, Evercare, exemplified the rolling out of a medicalised model of elder care (Kane, 2005; Ronch, 2004). The home was arranged very much as a hospital, with the 400 residents housed over several floors, each of which comprised four eight-bed wards and a shared communal area for eating and sitting (see Fig. 16.1).

Fig. 16.1 A Ward at Evercare [Photograph: Michael Tan, used with permission of Evercare]

The home catered for residents with a range of care needs. The majority are non-ambulant, requiring varying degrees of assistance from the staff with their daily needs such as toileting, showering and feeding while a small number are ambulant and largely able to manage their self-care. There are also residents who are fully bed-bound in late stage decline for whom the home effectively offers palliative care. It is due these residents that the terminology used for Evercare as a nursing rather than care, home, is justified. It is however, also these bed-ridden residents who are perhaps those who furnish the popular image in Singapore of the nursing home as a depressing place to inhabit:

> In actuality, those bed-ridden residents are simply left with a mouthful of breath. Have you see those that are in that state? Their eyes are always closed and they just keep breathing. Their eyes may open when you nudge them but will close shortly after. What can you expect from those residents? What do you want them to do? [Joe]

Another factor in creating a negative impression is that the ward structure offered almost no privacy and only little space for personal possessions. Residents were further depersonalised in being obliged to wear the nursing home's uniform pyjama-style clothes (Tan, 2017). The nursing home was, however, very clean and fresh-smelling at all times, and the environment

bright compared with others in the area (Tan, 2017), a point acknowledged by those residents who had visited several others which they described as, *"very dark and dirty"*. The nursing home, thus, delivered a high quality of care in relation to the physical concerns of environmental and bodily hygiene. Evercare was also attentive to the physical wellbeing of the residents, evident in the provision of activities for exercise and movement. The association of physical movement with continued health, in the sense of the absence of disease, of mental capacity and of capacity to carry out some functions appeared to be recognised and given primary emphasis in the nursing home through the employment of several physiotherapists. Additional activities, however, that hold the potential to enrich residents' cognitive and imaginative capacities and engender a sense of control and development in their life (see Edvardsson, 2008; de Macedo et al., 2015; de Oliveira et al., 2014) were rather limited. Even when these were available, as in the provision of puzzles or colouring sheets, staff were quick to highlight that these activities represented an additional strategy for maintaining motor coordination skills. While such activities might pass the time, their provision was nevertheless underpinned by medical rather than pleasure based reasoning. As Jess highlights,

> Our main focus is on the patients' physical hand movement. Creating an art piece is not our priority. We can give them different things to feel with their hands….All these activities provide tactile stimulation and encourage them to use their hands…. When using art, the occupational therapist is interested in stretching and strengthening and mobilising activities that accompany art making. [Jess, Therapist Aide]

An occupational therapist was contracted to provide reminiscence activities, bingo, art and crafts and cooking sessions, but these were held erratically and irregularly. On rare occasions, voluntary groups would visit the home to offer one-off cultural performance, a sing-a-long session or some kind of craft activity with the residents (Tan, 2017). However, the opportunity to participate in these was uneven given staff were not always available to help those with limited or no mobility access the event:

> There's singing on level two that they always asked me to join. But no one pushes me there. Whenever I request the ward staff to bring me, they would

> brush me off, telling me that I don't know how to sing, that I don't know the song. So I didn't go. They don't want to bring me there. [Mag]

Each floor has a communal space where residents could sit and interact informally, although few seem to do so. Taking up the chance to interact informally depends again on residents having sufficiently independent mobility as well as there being residents with interests in common on any specific floor,

> Sometimes, it's like making friends, if one doesn't share commonality on a topic of conversation, it is useless to speak another word…. you see, now we speak in different languages….. [Francis]

There seems to be little opportunity or encouragement for informal socialising beyond the formally organised physical exercise classes, a situation that resonates with the description of life in a care home as being 'alone together' (Turkle, 2012),

> When the session is on, the others will gather around to chitchat, that is good. But when you stop coming, the residents no longer come together. They don't come up." [Alice]

Residents themselves recognised that the care they were receiving was very medicalised and focused on their bodily maintenance. Several expressed concerns about the lack of mental, sensory or imaginative stimulation, particularly in contrast to the creative arts intervention:

> The nurse doesn't. They attend to things that concern our body. They don't take care of the ability of our mind and visual acuity. They don't. [Clare]

> You help residents pass the time, provide some interest for them to play. We don't get this from the nurses. They help out in taking care of our daily need, such as meals, medication. They are concerned about our safety, to ensure that you don't fall. [Joe]

The nursing home management team were aware that there could be better provision of stimulating and learning opportunities for the residents. But, as in many countries, the staff

was already working at full capacity with little time, inclination or skills to explore additional forms of care,

> ..because the health care staff will say that 'we don't have enough staff, how to carry out the activities.' How much the staff want to participate in the activity is a concern. [Agnes, Evercare manager]

> They don't have the kind of skills to facilitate the residents in to the art session kind of thing. [Agnes, Evercare manager]

Time management has also been flagged as an issue within residential care homes, with a medical model drawn from hospital structuring a tight schedule of maintenance tasks and with little spare capacity room for including additional tasks, such as taking a resident to join an activity:

> There is time management, due to the maintenance situation we have, we also have to communicate with the maintenance people, because we are back clashing by time. Because we are also facing a lot of the time we get clashes. Here the job is heavy duty. The problem is the time. [Jess, Therapist Aide]

This 'medical value of time' which puts a premium on physical health, disease and curing, has been subject to critique for some twenty years as it can result in neglected or suboptimal psychosocial care (see Henderson, 1995). It also underpins an argument for excluding those who may need additional support to participate in activity programmes, including those already displaying disengagement and who might most benefit (Kolanowski et al.,2006).

This medicalised approach to care reflects an underlying shared assumption of ageing bodies as incapable and passively dependent, a view recognised as compromising the wellbeing of residents (Meyer and Owen, 2008; Vladececk, 2003; Kane, 2001; Ronch, 2004; Gerritsen et al. 2004; Ryvicker, 2009) through generating processes such as learned helplessness, lower motivation and loneliness (Coudin and Alexopoulos, 2010).

> They are thinking that all the people here are already incapable. These things are not required. Daily leisure needs are not required. [Joe]

Moreover, the popular stigma attached to ageing bodies may be seen in ageist attitudes amongst staff in the nursing home with consequences on how care is conceptualised and delivered for the elderly in the home and expressed through staff behaviours that may be at best paternalistic and patronising, thereby diminishing dignity and self-esteem (Giles and Gasiorek, 2011) or worse, resulting in physical and emotional neglect (Angus and Reeve, 2006; Band-Winterstein, 2015). Residents are dependent on the staff for help with their physical needs, and are very aware of their vulnerability to staff attitudes in respect of this:

> Showers are carried out very quickly, in a slapdash manner. For non-communicative residents, showers may last less than two minutes while for the verbal they will take about five minutes- they are able to complain. [Joe]
>
> If they are in a good mood, they will perform their task well. But when they are not in a good mood….. [tails off, others describe rough handling] [Mag]

Acting to compound the vulnerability of the residents was the lack of structure within the management of Evercare through which residents could express their views and voice. Residents did offer suggestions during the research interviews thereby showing their ability to articulate ways to improve the nursing home. These included improvements to the environment through having more flowering plants and creating shady and cool spaces outside in which residents could relax. The model of care, however, echoed that of a hospital in which the residents are passive and subject to the expert care of the facility staff.

Making Art

Michael, a Singaporean artist, viewed the nursing homes he visited as leisure-scarce environments and responded by opening dialogue with the Evercare nursing home to set up an experimental participatory visual arts programme. This comprised twelve weekly sessions and introduced the group of ten participants to eight different creative projects that involved a mixture of two-dimensional and three-dimensional media (see Figures 2 and 3). The participants were recruited through a purposive sample (Patton, 2005) with the assistance of staff to identify potential and interested residents. The only criteria for participation was a willingness to be interviewed and a facility in one of the study languages (Mandarin, Teochew, Hokkien or English); there was no requirement for any prior experience with any visual arts approach. Michael treated the arts sessions as a form of creative assemblage (Fox, 2013) and

documented them through video, a research diary and subsequent interviews and group discussions with the ten participants and seven of the staff at the nursing home (see Tan, 2017; Tan, 2018). As such, the intervention shared much with an action-research approach in which Michael, as a reflexive practitioner, considered what it meant to work as a caring artist and generated a framework to capture his practice (Tan, 2018).

The intervention clearly benefited the participants as evidenced from their own descriptions of what they appreciated about the sessions and from observations made by others, particularly the staff, Michael and relatives. The arts engagement corresponded with the findings of many other arts and health projects in providing an opportunity for socialising and enjoyment,

> It is only through your session that we sat together. I became acquainted with them, conversations developed from the initial nodding of the head [Betty]

and for helping build and rebuild the participants' confidence and self-esteem:

> I doubt myself, not capable of art, in a way it's good for me to learn something new. At least I have tried something new for myself [Peter]

> I did not expect myself to splash so much. I didn't expect that I would know how to splash these. I see that I am quite clever [Alice]

Alice's comment, however, points at something that goes further than enjoyment and extends or underpins self-confidence; Alice is talking about a mixture of competence and creativity. Other participants also explicitly referenced the appreciation they had of the arts sessions in terms of learning new skills, gaining knowledge and producing a concrete and aesthetic output (see Fig. 16.2):

> You can help us improve our memory. You can also pass us knowledge. Otherwise, over here, there is not much knowledge. Beside reading newspapers and watching TV to gain knowledge, no-one has the means….. Very happy, very excited that I can produce a thing of such standard. I consider that is not a bad achievement for a disabled person to be doing this. I was challenging creating

the goldfish piece, because it was hard to manipulate the form of the fish. [Clare, who only has the use one arm]

Fig. 16.2 Examples of Residents' Artwork

The art, moreover, provided a means through which to assert to others their continuing competency, both to family and to the professional staff in the home:

> It is good to let the people outside know that the patient here has done something….Frame one for me so that when my family member comes, I will ask them to bring it home, bring back to home and display it in our, our house, our main hall [Peter]

> We never expected from Uncle [Joe] who did a perfect piece, we just though in the end it will be a simple piece. We never expected, I never expected that this piece will become like this. [Jess, Therapist Aide]

> Don't underestimate them actually, right? Because some times they can do really impossible things for us to see. Right, so continue to give the encouragement. I believe they can do even more for us to know, I think nothing is impossible. I think by nurturing they can be much better. [Matt, Staff]

In the context of the nursing home, the art sessions enabled participants to leave their ward, to meet other people from the home as well as engaging in the arts practice. Some participants were reliant on staff bringing them to the sessions and Michael did himself fetch

one or two residents on occasions to enable their continued participation. Whilst the opportunity to relieve the boredom of life in the nursing home might be offered by any range of activity sessions, the participants recognised the arts sessions as offering a particular benefit to their mental capacities. And this, again in the context of the nursing home, is of high significance for the participants:

> When you teach us things to do, we are alert. When you guys come and teach us things to do, our spirits are better [Alice]

> They can keep their mind going, instead of spending most of our time sleeping. I am afraid I will become demented. At least this is something that keeps the mind running [Betty]

> We can use our brain to think how we are going to accomplish the work. It can also train the eye. That is very good. You have to see as you create [Clare]

The creative practice offered in this project differed explicitly with the kinds of art and craft activities more commonly available. They offered particularly stark contrast to sets of colouring-in sheets. These reflect a format that is pre-structured and the output pre-determined with, as seen before, a primary focus on motor-coordination skills and time-passing.

> Your art activity is different. You lead them to discover and show their talents with using the colour, the clay, the paintings. [Jess, Therapist Aide]

> What the OT did wasn't something very dynamic. What you have done is something very different. Because, at the end of the project itself, erm, even with the watercolour, you don't have any base, outline for them to colour. You just let them fill the papers with colours ….. there was some beautiful work that is being done… and you allow the elderly to express it in their own way. You are not fixated, eh, you coloured out of line already, you know, we don't do that to the patient. So whereas your art is very free flowing in itself, it allows the patients or the resident to express their own sense of art work. [Agnes, Evercare Manager]

The nursing home manager and the physiotherapist fully understand the difference that these creative arts sessions offer compared with the highly structured occupational therapy sessions. The participants unpick this further to indicate how the openness of the creative arts sessions affords direct mental stimuli, exercise of the imagination, opportunities for expression and exploration, and aesthetic satisfactions (see Fig. 16.3):

> I can realise my imagination. I didn't think what I was going to create. I simply drew [Freddy]

> It is not the same. That you have to use your eyes, your mind, to figure out how to do the thing, how to pursue, how to do things to avoid damaging it. Colouring [sheets given by staff] is different. You simply colour. Even when it is not good, they [the staff] will still say it is good. That is not good. [Clare]

> I find myself using my brain, you make a decision about choice of colour [Francis]

> I never imagined myself to be creating this, it is all arbitrary and they do look adorable…..Even if it was an arbitrary effort, they came out to be quite adorable [Alice]

Fig. 16.3 Examples of Residents' 3-D Artwork

This acquisition of skills, the opportunity to exercise the imagination, to be expressive and creative and to produce an aesthetic product suggest that the arts and health intervention effectively valued and supported differently conceived goods for care. Here, the participants felt engaged, competent and able to continue forms of personal growth:

> You taught us how to draw, how to create. To appreciate the point of creation, the expression of it. This is something we don't know at all previously. It was from you that we learn and know what to do. [Betty]

This stimulation of mental capacities, engagement and creativity and the support of competency, aesthetics and learning, we argue constitutes caring for vitality. We use the term vitality in the sense of aliveness, in which feeling alive differs from being alive, as in Bergson's *élan vital* (Bergson, 1911) or Stern's *vital element* (Stern, 2010). For Stern, vitality is emergent from the connections and flows between five elements of movement, time, force, space and intentionality with its 'basis in physical action and traceable mental operations' (Stern 2010:9). He gives particular emphasis to the body and its own movements: '[t]he experience of vitality is inherent in the act of movement. Movement, and its proprioception, is the primary manifestation of being animate and provide the primary sense of aliveness' (Stern, 2010:9). The descriptions given by participants of their experiences of the creative arts programme detail the physical action and traceable mental operations of aliveness and vitality and thereby intimate the significance of offering an assemblage of movement, time, force, space and intentionality in the care home.

Multiplicity and Encounters in Cultures of Care

In interpreting the positive changes in mood and behaviours displayed by some of the participants, Agnes, the nursing home manager, relates these almost explicitly to a sense of empowerment that producing the art works may have engendered:

> the problem with the patient here is, they don't have the chance to gain ownership to an item very much. In this art programme, you can feel that, hey I made this, this is mine. So it gives them a sense of ownership….. I have never seen them, so proud in their lives before. I can see the happiness on the patients' faces, which is wonderful. Wonderful. [Agnes, Evercare Manager]

> Other staff intimated their recognition through the creative arts project of the potential of older bodies to become flourishing and productive bodies with the right support and care:
> They can blossom, they just need the motivation and encouragement for them each and everybody, they can come out from their lives [Jess, Therapist Aide]
>
> It will at least let people know that, yes they are old, they are sick but if you care enough, you show them your patience, they can be productive in a way, you know. They can show you the other side of themselves [Selma, Staff]
>
> If only we can give them time, give them opportunity, I believe they can do it definitely" [Matt, Staff]

The staff's appreciation of the intervention and the manager's insight into its benefits did not, however, translate into any evident plan to try to continue with any similar creatively directed practice in the home once Michael's intervention had ended. The staff did, nonetheless, feel obliged to offer explanations of why this was not possible, and these explanations, or logics, perhaps more than anything reveal tensions between different caring 'goods' and practices in deciding on the priorities for investing finite resources.

First, staff treated the success of the intervention as resulting from the exceptional qualities of this particular artist which effectively dismisses the experiment as potentially indicative of what partnership with creative practitioners more widely might bring or how a more creative practice might be engendered in existing staff:

> How you led the group made a big difference to the patients' art and their experience. The freedom they had in their creations, your encouragement, and prompting to get them to try different approaches when things didn't work. You showed versatility to work with different patients. You were sensitive to the residents' needs. [Agnes, Evercare Manager]

The management also invoked the limits on the care that could be provided within the finite resources available, both of money, time and personnel. Effectively, this reveals a culture of

care in which these aspects of care are valued but not prioritised as highly as maintenance and physical care, such that with:

> But here we also, difficult to manage because of the human resources. Then I also have some interest in the art, but .. there's no choice. I cannot manage my physiotherapy side, so I bring this to the occupational therapist side. I'm also thinking how to manage, how to keep this thing going. So we need you, we need you. [Susie, Physiotherapist]

The logic of care in the nursing home returns, by default, to an accountancy approach in which the value of investments in activities has to fit a standardised cost-effectiveness instrument:

> [let out a breath] Cost, will be an issue ! I have to look for finances to fund the programme itself. Especially the material costs. Let's say if I have an artist that comes in and on a volunteer basis, then of course I need to fund the project work being done. I cannot be expecting the artist to come out with money, that kind of thing. That in itself, then, I have to look for funding to create the projects …. Then we will need to see how much it benefits the patient in totality as number per se. If a group is too small, then it may not be very beneficial to pay the artist to do that. It has to be a group that is substantial enough, you know the kind of thing, so that we could actually, um, yeah, then the artist pay could be involved. [Agnes, Evercare Manager]

The explorations of what is valued as care by different constituencies and through different practices in the residential home of Evercare easily lend themselves to interpretation as two rather different, and conflicting, cultures of care. In the everyday routines of the nursing home, a medically informed culture of practice focusses on cleanliness, hygiene, safety and some maintenance of physical mobility and movement. The limited and somewhat irregular care provided for psycho-social dimensions of life often appear to meet descriptions of containment, occupation or entertainment that reflect and reinforce a limited view of the capacities of those in advanced ageing. There is little care given to vitality through supporting a more engaged forms of occupation that provide mental stimulation, opportunities for learning new skills and for developing and exercising competency. There is no care at all given to supporting empowerment and voice in decision-making. These absences, moreover, fit within a logic of care in which the significance of physical deterioration masks the potential

for other capacities. Michael, by contrast, as a creative practitioner supported and cared for vitality of these through the open-ended processes of art-making in which the participants themselves directed the process, made the key decisions and were only guided by the artists in developing new skills in using new artistic media. As an outsider coming into the nursing home, Michael himself viewed the culture of care as seriously lacking in leisure and enrichment opportunities which he located within a mode of thinking about universal principles for justice in advanced ageing and for practice as a caring artist (see Tan, 2017; 2018).

We can, however, think this apparent neglect of care for vitality in advanced ageing in a different less oppositional and conflicting frame if we think in terms of a multiplicity of caring goods, logics and practices that are differently situated and embedded within caring landscapes and that are in constant and negotiated tension. The staff and the creative practitioner are very differently situated in relation to the residents. The majority of staff are low paid, migrant workers who are employed explicitly to do the hands-on caring work with and for bodies, what Huang and colleagues (2012: 198) refer to as 'dirty work'. The physiotherapy team is situated within their profession in which enabling particular forms of movement constitutes providing high quality care. Both the staff caring for bodily hygiene and the physiotherapists have been contracted to deliver these forms of care. Their time is already fully committed and they have little capacity or evident incentive to add extra caring roles to their workload. Michael, by contrast, has chosen to come to the nursing home as a volunteer to run the participatory arts sessions, and as such, always has the option to leave as his employment is elsewhere. The caring practices, then, come from different positionalities in the home, but nonetheless share many values. Everyone, the staff, the artist, the residents, value the attention given to hygiene and cleanliness of the environment and the residents. The erratic and unruly nature of bodies is a defining characteristic of advanced ageing (Mol et al., 2010). The inability of residents to care themselves for their bodies is a primary rationale for moving to a residential home and the need to provide assistance with these tasks is a primary rationale for why residential homes exist. Michael, coming into the home with a set of practices specifically targeting creativity, imagination and productivity, had the benefit of being able to take this bodily care as a given, which he explicitly acknowledged when making his choice of nursing home.

Tensions between caring goods and caring logics become evident beyond the practices of basic maintenance. The creative arts intervention thus extends rather than conflicts with what is already being done by articulating additional practices through caring for vitality, for mental stimulation, social interactions, learning opportunities and expression of competency, as equally central to the understanding of care in advanced ageing. The management team and other staff fully recognise the value of caring for vitality; where the tensions lies is in whether this is valued equally centrally as the routine care of bodily hygiene and physiotherapeutic exercise. The management team appear to only consider whether the kinds of activities that Michael has enacted could be 'added' to existing work practices, and conclude staff are already too busy and unwilling to commit themselves further. Within the existing funding model, additional activities would need to be provided through fund-raising, voluntary provision or donation. And in the contemporary dominance of accountancy practices within public sector management, the benefits would need to be what Mol refers to as 'squeezed' into single dimension scales (2010).

The research, by staging an encounter of the everyday care practices with the exceptional practices of the caring artist, effectively produced a space of negotiation between these different practices and logics of care concerning the position of different goals or 'goods' of care in relation to one another. All constituencies, the management, the residents and the creative practitioner all effectively mobilised a hierarchy of care in which cleanliness of the environment and of the residents was prioritised. Beyond this, however, there were tensions across the different constituencies regarding the relative importance of other care goods. The management invoked a medical approach in which physical care of the body through movement became the next priority in the provision of care. Care for occupying the residents' time was provided through a basic offer of TV, newspapers, colouring sheets or puzzles. As such, the logic of care was premised on the centrality of the physical, material body. The creative practitioner, by contrast, offered a logic of care that was premised on what we have termed vitality. Vitality recognises a distinction between being alive and feeling alive and, whilst physical movement is crucial in connecting to mental and emotional vitality, the exercise of mental capacity, imagination and creativity prompted a greater alertness in the participants, as observed by both the practitioner and the staff.

This excursion through the values given to different forms of caring practice for residents in a Singaporean nursing home raises several inter-related issues about how we think through and think with a notion of care. Attending to the practices and logics of care in terms of multiplicity and negotiation allows for a greater sensitivity to how different goods are valued, prioritised or dismissed. This permits a broader spectrum of potential values from different perspectives to inform how care in advanced ageing is conceptualised and delivered. Our experiences in the nursing home nonetheless leave us dismayed at the lack of value given to the residents' vitality and we find it hard to let go of a wish for a universal principle premised on the right for care in advanced ageing. This prompts us to contemplate the different academic cultures of care, of universal rights and of locally specific ethics and practices, and ask whether we can find a way also to better negotiate between these and 'tinker' with different goods mapping onto different dimensions to care.

Acknowledgements

The empirical research was supported through a Postgraduate Arts Scholarship from the National Arts Council of Singapore and subsequent conceptual work supported through a Wellcome Trust Development Award to Durham University (WT209513). We especially acknowledge and express our gratitude to all the staff and participants at 'Evercare' nursing home who generously gave their time, care and insights to the work.

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